		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004499

Facility Name: Bel-Wood Nursing Home

Address: 6701 W. Plank Road (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309) 697-4541 **Fax #** (309) 697-6622

IDPA ID Number: 069-333-049-001

Date of Initial License for Current Owners: 11/30/68

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Stephen Johnson **Telephone Number:** (309) 697-4541

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Stephen Johnson
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address) see attached compilation report
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,418	7,586	4,414	41,418	8
9	SNF/PED					9
10	ICF	32,824	17,826	628	51,278	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,242	25,412	5,042	92,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.65%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/30/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 2,983

Medicare Intermediary AdminaStar Federal, Inc

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	608,414	51,033		659,447		659,447		659,447			1
2	Food Purchase		391,098		391,098		391,098	(10,514)	380,584			2
3	Housekeeping	497,314	34,364	15,403	547,081		547,081		547,081			3
4	Laundry	175,338	27,931		203,269		203,269		203,269			4
5	Heat and Other Utilities			278,657	278,657		278,657		278,657			5
6	Maintenance	109,459	55,086	38,743	203,288		203,288	29,870	233,158			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,390,525	559,512	332,803	2,282,840		2,282,840	19,356	2,302,196			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	3,185,393	324,546	2,535,373	6,045,312		6,045,312		6,045,312			10
10a	Therapy	67,853		145,808	213,661		213,661		213,661			10a
11	Activities	225,290	7,756	866	233,912		233,912	(1,706)	232,206			11
12	Social Services	175,085		5,526	180,611		180,611		180,611			12
13	Nurse Aide Training											13
14	Program Transportation			197	197		197		197			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,653,621	332,302	2,692,770	6,678,693		6,678,693	(1,706)	6,676,987			16
	C. General Administration											
17	Administrative	61,828		52,578	114,406		114,406	(52,578)	61,828			17
18	Directors Fees							70,188	70,188			18
19	Professional Services			413,705	413,705		413,705	(38,854)	374,851			19
20	Dues, Fees, Subscriptions & Promotions			16,441	16,441		16,441	(3,370)	13,071			20
21	Clerical & General Office Expenses	401,507	3,429	56,105	461,041		461,041	307,795	768,836			21
22	Employee Benefits & Payroll Taxes			774,773	774,773		774,773	763,795	1,538,568			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,040	4,040		4,040		4,040			24
25	Other Admin. Staff Transportation			4,050	4,050		4,050		4,050			25
26	Insurance-Prop.Liab.Malpractice			38,040	38,040		38,040	47,041	85,081			26
27	Other (specify):*			1,138	1,138		1,138		1,138			27
28	**TOTAL General Administration**	463,335	3,429	1,360,870	1,827,634		1,827,634	1,094,017	2,921,651			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,507,481	895,243	4,386,443	10,789,167		10,789,167	1,111,667	11,900,834			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bel-Wood Nursing Home 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			286,190	286,190		286,190		286,190			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			286,190	286,190		286,190		286,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			164,250	164,250		164,250		164,250			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,507,481	895,243	4,836,883	11,239,607		11,239,607	1,111,667	12,351,274			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,983)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,551)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(531)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,103)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,370)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule patient activity	(1,706)	11		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,244)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,145,911		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,145,911		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,111,667		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Bel-Wood Nursing Home

ID# 0004499

Report Period Beginning: 1/1/2002

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	patient activities	$ (1,706)	11	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,514)	0	0	0	0	0	0	0	0	0	0	(10,514)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	29,870	0	0	0	0	0	0	0	0	0	29,870	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,514)	29,870	0	0	0	0	0	0	0	0	0	19,356	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,706)	0	0	0	0	0	0	0	0	0	0	(1,706)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,706)	0	0	0	0	0	0	0	0	0	0	(1,706)	16
	C. General Administration													
17	Administrative	0	(52,578)	0	0	0	0	0	0	0	0	0	(52,578)	17
18	Directors Fees	0	70,188	0	0	0	0	0	0	0	0	0	70,188	18
19	Professional Services	0	(38,854)	0	0	0	0	0	0	0	0	0	(38,854)	19
20	Fees, Subscriptions & Promotions	(3,370)	0	0	0	0	0	0	0	0	0	0	(3,370)	20
21	Clerical & General Office Expenses	(13,551)	321,346	0	0	0	0	0	0	0	0	0	307,795	21
22	Employee Benefits & Payroll Taxes	(5,103)	768,898	0	0	0	0	0	0	0	0	0	763,795	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	47,041	0	0	0	0	0	0	0	0	0	47,041	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,024)	1,116,041	0	0	0	0	0	0	0	0	0	1,094,017	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,244)	1,145,911	0	0	0	0	0	0	0	0	0	1,111,667	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bel-Wood Nursing Home** **# 0004499** **Report Period Beginning:** **1/1/2002** **Ending:** **12/31/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,244)	1,145,911	0	0	0	0	0	0	0	0	0	1,111,667	45

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Facilities Management	$	Peoria County	100.00%	$ 29,870	$ 29,870	1
2	V	17	Management Fee	52,578	Peoria County	100.00%		(52,578)	2
3	V	18	County Board		Peoria County	100.00%	70,188	70,188	3
4	V	19	Professional Services	137,879	Peoria County	100.00%	99,025	(38,854)	4
5	V	21	Clerical Services		Peoria County	100.00%	321,346	321,346	5
6	V	22	Employee Benefits	198,589	Peoria County	100.00%	444,165	245,576	6
7	V	26	Liability Insurance	38,040	Peoria County	100.00%	85,081	47,041	7
8	V	22	IMRF		Peoria County	100.00%	114,384	114,384	8
9	V	22	FICA		Peoria County	100.00%	408,938	408,938	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 427,086			$ 1,572,997	$ * 1,145,911	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Peoria County
Street Address: Rm 401, Peoria County courthouse
City / State / Zip Code: Peoria, IL 61602
Phone Number: (309) 672-6056
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Facilities Management	Direct Allocation per			$	$		$ 29,870	1
2										2
3	18	County Board	DMG-Maximus, Inc.						70,188	3
4	19	Professional Services							99,025	4
5	21	Clerical services	(see attached schedules)						321,346	5
6										6
7	22	Employee Benefits	(further detail available upon request)						444,165	7
8	26	Liability Insurance							85,081	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,049,675	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bel-Wood Nursing Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0004499

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,800 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	8 acres	1848	$ 100	1
2					2
3	TOTALS	#VALUE!		$ 100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1969	1969	$ 3,123,273	$ 62,465	50	$ 62,465	$	$ 2,123,822	4
5			1975	1975	4,223	94	45	94		2,629	5
6			1986	1986	47,151	1,566	various	1,566		43,328	6
7											7
8											8
	Improvement Type**										
9	Improvements			1978	10,851	271	40	271		6,801	9
10	Improvements			1979	43,777	960	20-25	960		43,768	10
11	Improvements			1980	115,619		20-25			115,619	11
12	Improvements			1983	968		15			968	12
13	Improvements			1984	22,787		various			22,787	13
14	Improvements			1985	512,902	25,244	various	25,244		471,771	14
15	Improvements			1986	48,090	2,405	20	2,405		40,282	15
16	Improvements			1987	23,252		various			23,252	16
17	Improvements			1988	132,642	7,156	various	7,156		101,690	17
18	Improvements			1989	176,637	9,525	various	9,525		125,849	18
19	Improvements			1990	194,031	2,253	various	2,253		194,031	19
20	Improvements			1991	1,058,535	51,696	various	51,696		607,393	20
21	Improvements			1992	192,921	10,299	various	10,299		112,273	21
22	Painting			1993	729		5			729	22
23	Driveway			1994	1,453	145	10	145		1,185	23
24	Improvements			1995	7,608	414	16-20	414		3,002	24
25	Building Improvements			1995	41,142	2,390	5-20	2,390		22,804	25
26	Resurface Driveway			1996	2,947	184	16	184		1,012	26
27	Activity Area Remodeling			1996	258	16	16	16		110	27
28	Draperies			1996	1,218	122	10	122		772	28
29	Resident Room Remodeling			1996	1,174	78	15	78		430	29
30	Resident Room Remodeling			1996	1,440	96	15	96		528	30
31	Telephone Wiring			1996	2,383	119	20	119		635	31
32	Draperies			1996	2,691	269	10	269		1,435	32
33	Resident Room Remodeling			1996	3,977	265	15	265		1,855	33
34	Resident Room Remodeling			1996	696	46	15	46		276	34
35	Faucets			1997	1,862	93	20	93		473	35
36	Replace Floor			1997	1,035	52	20	52		264	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Motor	1997	$ 1,022	$ 102	10	$ 102	$	$ 510	37
38	Remodeling	1997	1,923	96	20	96		541	38
39	Door Replacement	1997	4,957	248	20	248		1,447	39
40	Ceiling Tile	1997	1,488	99	15	99		569	40
41	Concrete Slabs	1997	825	41	20	41		229	41
42	Renovation of Study	1997	4,900	490	10	490		2,940	42
43	Sinks	1997	3,718	186	20	186		1,007	43
44	Plumbing	1997	2,397	96	25	96		520	44
45	Lights	1997	12,479	693	18	693		4,158	45
46	Compressor	1997	5,680	379	15	379		2,021	46
47	Wire	1997	337	17	20	17		88	47
48	Energy Management System	1998	717	143	5	143		644	48
49	Flourescent Lamps	1998	1,458	292	5	292		1,387	49
50	Fireplace	1998	946	47	20	47		212	50
51	Water Pressure Pump	1998	2,226	223	10	223		985	51
52	Bi-Fold Doors	1998	27,343	2,734	10	2,734		10,936	52
53	Sink system	1998	2,569	128	20	128		598	53
54	Handrails	1998	1,955	196	10	196		882	54
55	Water Softner	1998	34,106	2,842	12	2,842		12,315	55
56	Wire	1998	659	33	20	33		151	56
57	Roof Repair	1998	3,760	376	10	376		1,723	57
58	Draperies	1998	874	58	15	58		242	58
59	Borderwork	1998	840	56	15	56		261	59
60	Borders	1998	285	19	15	19		85	60
61	Covebase	1998	353	24	15	24		108	61
62	Covebase	1998	46	3	15	3		14	62
63	Wallpaper	1998	985	49	20	49		225	63
64	Wallpaper	1998	1,885	94	20	94		439	64
65	Wallpaper	1998	1,075	54	20	54		256	65
66	Wallpaper	1998	434	22	20	22		95	66
67	Roof Repairs	1998	3,467	347	10	347		1,388	67
68	Draperies	1998	1,872	125	15	125		500	68
69	Underground Storage Tank	1998	26,041	651	40	651		3,255	69
70	TOTAL (lines 4 thru 69)		$ 5,931,894	$ 189,186		$ 189,186	$	$ 4,122,504	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,931,894	$ 189,186		$ 189,186	$	$ 4,122,504	1
2	Energy management system modifications	1999	3,732	373	10	373		1,368	2
3	Curtains	1999	797	80	10	80		286	3
4	Roof Repairs	1999	1,254	84	15	84		294	4
5	Shelving, dish room	2000	1,500	75	20	75		206	5
6	Door relocation	2000	1,461	73	20	73		195	6
7	Roof Repairs	2000	3,552	237	15	237		612	7
8	Water main #1	2000	3,178	127	25	127		318	8
9	Housing Assembly	2000	874	87	10	87		218	9
10	Sidewalk Replacement	2000	1,350	68	20	68		170	10
11	Draperies	2000	4,839	484	10	484		1,170	11
12	Water main #2	2000	2,120	85	25	85		198	12
13	Draperies	2000	728	73	10	73		164	13
14	Door guards	2000	1,694	85	20	85		191	14
15	Door, magnetic lock	2000	4,062	203	20	203		440	15
16	Replacement glass	2001	2,971	149	20	149		285	16
17	Fire system	2001	496	62	8	62		114	17
18	Water heater replacement	2001	84,666	10,583	8	10,583		18,274	18
19	Drawer front machine	2001	1,690	113	15	113		198	19
20	Paint	2001	5,028	1,006	5	1,006		1,676	20
21	Roof sealant	2001	1,039	208	5	208		225	21
22	Windows	2002	59,439	743	20	743		743	22
23	Resident Alarm System	2002	43,538	181	20	181		181	23
24	Exit Device	2002	1,862		10				24
25	Egress Bars for doors	2002	2,630	22	10	22		22	25
26	Rooftop Unit Pilot Program Phse 1	2002	1,420		15				26
27	Construction Documents	2002	6,750		8				27
28	Control Wiring	2002	2,495	73	20	73		73	28
29	Roof Repairs	2002	1,642	82	15	82		82	29
30	Architect fees per IDPA review of 1999 cost report	1999	15,290						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,193,991	$ 204,542		$ 204,542	$	$ 4,150,207	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 784,785	$ 71,396	$ 71,396	$	5 to 20	$ 386,534	71
72	Current Year Purchases	20,307	1,278	1,278		5 to 20	1,278	72
73	Fully Depreciated Assets	609,954	7,224	7,224		5 to 20	609,954	73
74								74
75	TOTALS	$ 1,415,046	$ 79,898	$ 79,898	$		$ 997,766	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2001 Dodge Ram Truck	2000	$ 13,998	$ 1,750	$ 1,750	$	8	$ 4,521	76
77	Maintenance	1989 Chevy bus	1989	8,388				5	8,388	77
78	Business	Auto	1995	13,077				4	13,077	78
79	Resident	1997 Ford Eldorado	1997	42,701				4	42,701	79
80	TOTALS			$ 78,164	$ 1,750	$ 1,750	$		$ 68,687	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,687,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,190	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,190	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,216,660	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,951	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 371,465)	1,006,924		3
4	Supply Inventory (priced at cost)	59,941		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,079,816	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100		13
14	Buildings, at Historical Cost	5,978,801		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,493,210		16
17	Accumulated Depreciation (book methods)	(4,861,841)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,610,270	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,690,086	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 363,921	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	643,164		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Other Funds	3,307,316		36
37	Deferred Revenue	239,120		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,553,521	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,553,521	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (863,435)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,690,086	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,049,929	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,049,929	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,754,330)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **dif in method used for acctng for payroll**	(147,315)	15
16	Other (describe) **dif in method used for depreciation**	(11,719)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,913,364)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (863,435)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,845,572	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,845,572	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	620,904	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,983	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 630,887	23
	D. Non-Operating Revenue		
24	Contributions	1,786	24
25	Interest and Other Investment Income***	108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,894	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see attached summary	6,924	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,924	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,485,277	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,282,840	31
32	Health Care	6,678,693	32
33	General Administration	1,827,634	33
	B. Capital Expense		
34	Ownership	286,190	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,239,607	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,754,330)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,754,330)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** n/a **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,458	13,845	322,375	23.28	3
4	Licensed Practical Nurses	29,464	33,511	596,767	17.81	4
5	Nurse Aides & Orderlies	149,362	171,764	2,229,335	12.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,670	2,232	53,645	24.03	9
10	Activity Assistants	9,316	10,680	171,645	16.07	10
11	Social Service Workers	8,553	10,346	175,085	16.92	11
12	Dietician					12
13	Food Service Supervisor	1,764	2,415	50,197	20.79	13
14	Head Cook	1,992	2,256	35,648	15.80	14
15	Cook Helpers/Assistants	41,292	47,894	522,569	10.91	15
16	Dishwashers					16
17	Maintenance Workers	6,247	7,278	109,459	15.04	17
18	Housekeepers	43,063	49,772	497,314	9.99	18
19	Laundry	14,409	16,313	175,338	10.75	19
20	Administrator	1,440	1,584	61,828	39.03	20
21	Assistant Administrator					21
22	Other Administrative	3,310	4,500	92,532	20.56	22
23	Office Manager					23
24	Clerical	20,039	24,606	308,975	12.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	3,346	3,943	67,853	17.21	30
31	Medical Records	2,616	3,240	36,916	11.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	349,341	406,179	$ 5,507,481 *	$ 13.56	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant		3,040	L10-C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400	L10-C3	39
40	Physical Therapy Consultant	1,874	77,443	L10a-C3	40
41	Occupational Therapy Consultant	1,331	41,591	L10a-C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	442	19,914	L10a-C3	43
44	Activity Consultant	19	866	L11-C3	44
45	Social Service Consultant	105	5,526	L12-C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,771	$ 150,780		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	11,211	$ 433,124	L10-C3	50
51	Licensed Practical Nurses	35,873	1,281,187	L10-C3	51
52	Nurse Aides	38,985	810,264	L10-C3	52
53	TOTAL (lines 50 - 52)	86,069	$ 2,524,575		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephen Johnson	Administrator	0	$ 61,828
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,828

B. Administrative - Other

Description	Amount
Peoria County Management Fees	$ 52,578
TOTAL (agree to Schedule V, line 17, col. 3)	$ 52,578
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Peoria County	data processing	$ 137,879
Clifton Gunderson LLP	accounting	14,450
Duane Morris	legal	136,475
Enloe	data processing	3,300
Med line	data processing	1,804
Atlas	data processing	705
Administar Federal, Inc.	management	25
Circle of Quality, Inc.	management	119,067
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 413,705

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,515
Unemployment Compensation Insurance	(6,197)
FICA Taxes	408,938
Employee Health Insurance	991,726
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	114,384
background checks	2,202
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,538,568

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,562
Health Care Worker Background Check	
(Indicate # of checks performed)	
Books and periodicals	1,864
HCFA Laboratory	150
Life Services	750
Illinois Medical Directors Assoc	70
LSN	2,970
Sam's Club	75
Less: Public Relations Expense	( )
Non-allowable advertising	(3,370)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,071

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
None	
In-State Travel	
Seminar Expense	
(see attached schedule)	4,040
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,040

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/2002 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. LSN $2,970

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 11.4

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 62,506 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 164,250
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ none Has any meal income been offset against related costs? yes Indicate the amount. $ 9,983

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? 0%

d. Have vehicle usage logs been maintained? yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a

g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ n/a

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Audit is currently in progress

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.